Please print clearly to ensure accurate processing

GUARDIAN®

Employer:
Karuk Tribe
64236 Second Ave
Happy Camp, CA 96039

Guardian Group Plan Number: **447691**

The Guardian Life Insurance Company of America

EMPLOYER USE ONLY ❑ New Application ❑ Add Dependent(s) ❑ Drop Dependent(s) ❑ Change Address ❑ Change Name ❑ Drop Coverage as of: / /

Class	Hours Worked	Division	Benefits Effective
All Eligible Employees			/ /

Keep a copy for your records and return form to: **Midwest Regional Office, P.O. Box 8012, Appleton, WI 54912-8012**

ABOUT YOURSELF

Print clearly in black or blue ink.

First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -

Address	City	State	Zip

Preferred E-mail	Day Phone	Eve Phone	The best way to reach you: ❑ E-mail ❑ Day Phone ❑ Eve Phone

Job Title	Work Status ❑ Full-Time ❑ Part-Time ❑ Retired ❑ COBRA/State Continuation	Date work status began / /	Annual Salary/Earnings $

Are you married? ❑ Yes ❑ No If you have a domestic partner (DP), is your partnership registered with the State of California? ❑ Yes ❑ No

Do you have children or other dependents? ❑ Yes ❑ No

ABOUT YOUR DEPENDENTS

❑ A sheet with information about additional dependents is attached.

Spouse/DP First, Middle Initial, Last Name ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	Social Security Number - -	Marriage Date (mm/dd/yyyy) / /	
Child 1 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 2 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 3 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /
Child 4 ❑ Add ❑ Change ❑ Drop	Sex ❑ M ❑ F	Date of Birth (mm/dd/yyyy) / /	❑ Full-time student, at (school):	City/State:	Attending Since / /

To drop coverage for yourself or your dependents, check the box(es) to the right of the name(s) and select the coverage(s) to drop below. Attach a separate sheet if you wish to drop more than one dependent from different coverages.
❑ Basic Life ❑ Voluntary Life ❑ AD&D ❑ Dental ❑ Vision

YOUR BASIC LIFE COVERAGE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

	Policy Amount
Employee	☑ $15,000

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $ _____

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jul 25, 2013

LIFE INSURANCE *continued*

Name your beneficiaries		Primary beneficiaries must total 100%.
Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Percent %
Primary Beneficiary 2		%
Contingent Beneficiary		%

In the event the designated primary beneficiaries are deceased, the contingent beneficiary will receive the benefit.

CHOOSE YOUR VOLUNTARY TERM LIFE COVERAGE

Check one box only

Employee

Policy Amount — You must be enrolled to cover your dependents.

❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000	❑ $60,000
❑ $70,000	❑ $80,000	❑ $90,000	❑ $100,000	❑ $110,000	❑ $120,000
❑ $130,000	❑ $140,000	❑ **$150,000***	❑ $160,000	❑ $170,000	❑ $180,000
❑ $190,000	❑ $200,000	❑ $210,000	❑ $500,000		

$_____

**Guarantee Issue Amount*

❑ I waive this coverage

Add Voluntary Life for Spouse/DP — *Check one box only*

❑ 50% of employee's amount to maximum $250,000

❑ I waive this coverage

The amount may not be more than 50% of the employee amount for Voluntary Life.

Add Voluntary Life for Child(ren) — *Check one box only*

❑ 10% of employee's amount to maximum $10,000

❑ I waive this coverage

The amount may not be more than 10% of the employee amount for Voluntary Life.

❑ A separate sheet for Voluntary Term Life beneficiaries is attached if they are not the same as those named for Basic Life.

For Voluntary Life, an Evidence of Insurability form must be completed for any amount above the Guarantee Issue.

IMPORTANT NOTES

- If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian reserves the right to reject your request.
- Children will not be covered until they reach 14 days.
- Based on your plan benefits and your age, you may be required to complete an additional evidence of insurability form for Voluntary Life and/or Guardian Universal Life.

CHOOSE ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Check one box only

Policy Amount

Employee	❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000
	❑ $100,000	❑ $120,000	❑ $150,000	❑ $200,000	❑ $250,000
	❑ $300,000	❑ $350,000	❑ $400,000	❑ $450,000	❑ $500,000

❑ I waive this coverage

Add Entire Family (includes Employee, Spouse/DP and Child(ren))	❑ $10,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000
	❑ $100,000	❑ $120,000	❑ $150,000	❑ $200,000	❑ $250,000
	❑ $300,000	❑ $350,000	❑ $400,000	❑ $450,000	❑ $500,000

❑ I waive this coverage

You must be enrolled to cover your dependents.

Guardian Group Plan Number: **447691**

Please print employee name:

CHOOSE YOUR DENTAL COVERAGE				*Check one box only*
	PPO			
Employee alone	❑			❑ I waive this coverage
Employee and Spouse/DP	❑			❑ I waive this coverage
Employee and Child(ren)	❑			❑ I waive this coverage
Entire family	❑			❑ I waive this coverage

If you or your family have lost dental coverage, please explain below. Late entry penalties may apply.	
Reason for Loss of coverage: ❑ Termination of Employment ❑ Divorce ❑ Death of Spouse/DP ❑ Termination or Expiration of coverage	Date of coverage loss / /
If you are waiving coverage, are you covered under another dental plan? ❑ Yes ❑ No	If you are waiving dependent coverage, are your dependents covered under another dental plan? ❑ Yes ❑ No

IMPORTANT NOTES

- Proof of insurability does not apply to dental, but if you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse/DP, divorce or where a court has ordered coverage be provided for an eligible spouse/DP or eligible children, provided you apply within 30 days.

CHOOSE YOUR VISION COVERAGE				*Check one box only*
	Full Feature			
Employee alone	❑			❑ I waive this coverage
Employee and Spouse/DP	❑			❑ I waive this coverage
Employee and Child(ren)	❑			❑ I waive this coverage
Entire family	❑			❑ I waive this coverage

If you are waiving coverage, are you covered under another vision plan? ❑ Yes ❑ No	If you are waiving dependent coverage, are your dependents covered under another vision plan? ❑ Yes ❑ No

IMPORTANT NOTES

- If I have waived the vision coverage, and elect coverage at a later date, enrollment delays may apply.
- Your plan includes a One Year Lock-In/Lock-Out Provision - Your election to enroll in or waive vision coverage must remain in effect until your plan's next annual vision enrollment period.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

SIGNATURE

- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I agree that my employer may deduct premiums from my pay or add premiums to my dues; if they are required for the coverage I have chosen above.
- I understand that the premium amounts shown above are estimations. If the premium amounts shown above and the deductions for premiums shown on my paycheck stub do not agree, my paycheck stub will prevail. I understand that the premium amounts may be amended.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

SIGNATURE OF EMPLOYEE X _____ **DATE** _____